

<b>Case Number:</b>	CM13-0062842		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/27/2007
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47-year-old male who reported an injury on 09/27/2007. The mechanism of injury was not provided. On 02/28/2013, the injured worker presented with pain and discomfort to his left shoulder. Prior therapy included medications, injections, rest, and physical therapy. The diagnoses were left knee arthroscopic surgery on 01/04/2008, MRI of the left shoulder dated 04/19/2011 revealing a rotator cuff tear impingement with subacromial bursitis, MRI studies of the left knee from 01/16/2013 showing severe multicompartamental osteoarthritis, and status post synovisc for the left knee. Upon examination, there were stiffness and discomfort with prolonged weightbearing activities. The provider recommended physical therapy 2 times a week for 6 weeks for the left knee. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**PHYSICAL THERAPY, TWO (2) TIME PER WEEK FOR SIX (6) WEEKS FOR THE LEFT KNEE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, page(s) 98 Page(s): 98.

**Decision rationale:** The request for physical therapy 2 times a week for 6 weeks for the left knee is not medically necessary. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process and/or to maintain improvement levels. The guidelines recommend 10 visits of physical therapy for 4 weeks. There was a lack of documentation indicating the injured worker's prior course of physical therapy as well as efficacy of the prior therapy. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process, and there are not significant barriers to transitioning the injured worker to an independent home exercise program. Therefore, the request is not medically necessary.